CALIFORNIA PCIP Pre-Existing Condition Insurance Plan

PCIP Supplemental Application Overview

California now offers a federally-funded Pre-Existing Condition Insurance Plan (PCIP), for medically-uninsurable Californians. The California Major Risk Medical Insurance Program (MRMIP) is a separate state program for medically uninsurables with different rules.

When you apply for the PCIP and/or MRMIP, your application will be reviewed for ***both*** health care programs to inform you of your coverage options. In order for your eligibility to be determined for ***both*** programs, you need to fill out both the PCIP supplemental application and the MRMIP application.

If you qualify for both programs, we will enroll you in the program you indicate that you prefer in Question 13, or we will contact you if you didn't respond to the question.

The MRMIP has an enrollment cap, which limits the number of individuals that can be enrolled. Applications will be processed on a first come, first served basis.

Important Notice: If you are currently or will be enrolled in the MRMIP, you ***will not*** qualify for the PCIP. The PCIP requires that an individual not have health insurance coverage for at least six (6) months, prior to receiving your application.

Each individual applying for the PCIP must complete their own application because the PCIP does not offer dependent coverage.

The PCIP and MRMIP have different eligibility rules, benefits and monthly premiums. The charts on the following page (page 2) compare the two programs.

Questions? You can visit **www.pcip.ca.gov** or **www.mrmib.ca.gov** for more information. Call **1-877-428-5060** Monday through Friday 8:00 AM – 8:00 PM, Saturday 8:00 AM – 5:00 PM.

PCIP and MRMIP Eligibility Rules

Pre-Existing Condition Insurance Plan (PCIP) (Federal)	Major Risk Medical Insurance Program (MRMIP) (State)
▪ Resident of California	▪ Resident of California
▪ A pre-existing condition as shown by: ◆ Rejection letter from a health insurance company in the last 12 months, **or** ◆ Offered coverage with premiums higher than those of the MRMIP preferred provider organization (PPO) in the geographic region where the individual is seeking coverage.	▪ A pre-existing condition as shown by: ◆ Rejection letter from a health insurance company in the last 12 months, **or** ◆ Offer of premiums equal to or higher than those of the individual's first MRMIP plan choice, **or** ◆ Termination by an insurance carrier for reasons other than fraud or non-payment of premiums, ineligibility.
▪ U.S. Citizen, U.S. National or lawfully present.	
▪ No health insurance coverage in the last six months prior to application.	
▪ Not enrolled in Medicare Part A & Part B; or COBRA or Cal-COBRA benefits.	▪ Not eligible for Medicare Part A or Part B (except for end stage renal disease), or COBRA or Cal-COBRA benefits.
▪ Social Security Number required.	▪ Social Security Number **not** required.
▪ Dependent coverage **not** available.	▪ Dependent coverage available.

PCIP and MRMIP Benefits and Cost Comparison Chart	(Federal) **PCIP**	(State) **MRMIP**
Annual deductible	$1,500	$500
Brand name drug deductible	$500	None
Annual out of pocket maximum	$2,500	$2,500
Annual benefit cap	None	$75,000
Lifetime benefit cap	None	$750,000
Health care provider source	CA Physicians' Service, Inc. PPO Network	Anthem Blue Cross, Contra Costa, Kaiser
Premium comparison chart	See page 5 of this PCIP Supplemental application	See pages 16-21 of the MRMIP application
Pre-existing condition exclusion period	None	3 months

For more information on PCIP benefits, go to **www.pcip.ca.gov.**

For more information on MRMIP benefits, go to **www.mrmib.ca.gov.**

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California Pre-Existing Condition Insurance Plan Benefits

Type of service	Description of service	What subscribers pay participating provider	What subscribers pay non-participating provider
Annual deductible	The amount that a subscriber must pay for covered services except for preventive care services before the program will cover those services at the copayment or coinsurance amount in one calendar year.	$1,500 per subscriber	$3,000 per person – does not count toward in-network deductible
Annual deductible – brand name drug deductible	The amount that a subscriber must pay for brand-name drugs before the program will cover those drugs at the copayment or coinsurance amount in one calendar year.	$500 per subscriber	$500 per person – does not count toward in-network deductible
Copayment/coinsurance	Subscriber's amount due and payable to the provider of care	See below	See below
Annual maximum copayment/ coinsurance limit	Subscriber's annual maximum copayment/coinsurance limit when using participating providers in one calendar year ▪ The annual maximum copayment/coinsurance includes the $1,500 annual deductible and the $500 annual deductible for brand-name drugs ▪ If nonparticipating providers are used, billed charges which exceed the customary and reasonable charges are the subscriber's responsibility and do not apply to the annual maximum copayment/ coinsurance limit	$2,500 per subscriber	No annual maximum copayment/coinsurance limit for non-participating providers. Subscribers pay unlimited coinsurance
Annual benefit maximum	There is no annual benefit maximum in this program	None	None
Lifetime benefit maximum	There is no annual benefit maximum in this program	None	None
Preventive care services*	Preventive services: Breast exams, pelvic exams, pap smears, and mammograms for women, Human Papillomavirus (HPV) screening test, ovarian and cervical cancer screening, cytology examinations, family planning services, health education services, periodic health examinations and laboratory services in connection with them, hearing and vision exams for children, newborn blood tests, prenatal care (care during pregnancy), prostate exams for men, sexually transmitted infections (STI) tests, Human Immunodeficiency Virus (HIV) testing, well-baby and well-child visits, certain immunizations for children and adults, and disease management programs	No charge	50% of customary and reasonable charges and any in excess
Hospital services	▪ Inpatient medical services (semi-private room)	15% of negotiated fee rate	50% of customary and reasonable charges and any in excess
	▪ Outpatient services; ambulatory surgical centers	15% of negotiated fee rate	50% of customary and reasonable charges and any in excess
Physician office visits	Services of a physician for medically necessary services	$25 copayment per visit	50% of customary and reasonable charges and any in excess
Diagnostic X-ray and lab services*	Outpatient diagnostic X-ray and laboratory services	15% of negotiated fee rate	50% of customary and reasonable charges and any in excess
Prescription drugs	▪ Maximum 30-day supply per prescription when filled at a participating pharmacy ▪ 90-day supply for mail order	$5 for generic drugs After the annual $500 brand-name deductible is met: ▪ $15 for formulary brand-name ▪ $30 for non-formulary brand-name drugs and specialty drugs (need pre-authorization for specialty) Same copayments for mail order	Full cost of drugs at non-participating pharmacy; program reimburses subscriber 50% of generic and brand name prescription drug fee schedule
Durable medical equipment and supplies	Must be certified by a physician and required for care of an illness or injury	15% of negotiated fee rate	50% of customary and reasonable charges and any in excess

* Preventive care services are covered with no charge even if subscribers have not met the annual deductible.

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California Pre-Existing Condition Insurance Plan Benefits *(continued)*

Type of service	Description of service	What subscribers pay participating provider	What subscribers pay non-participating provider
Pregnancy* and maternity care	▪ Inpatient normal delivery and complications of pregnancy	15% of negotiated fee rate	50% of customary and reasonable charges and any in excess
	▪ Prenatal *	No charge	50% of customary and reasonable charges and any in excess
	▪ Postnatal	15% of negotiated fee rate	50% of customary and reasonable charges and any in excess
Ambulance services	▪ Ground or air ambulance to or from a hospital for medically necessary services	15% of negotiated fee rate	50% of customary and reasonable charges and any in excess
Emergency health care services**	Initial treatment of an acute serious illness or accidental injury. Includes hospital, professional, and supplies	15% of negotiated fee rate	50% of customary and reasonable charges or billed charges, whichever is less plus any charges in excess of customary and reasonable for the first 48 hours
Mental health care services**	▪ Inpatient basic mental health care services 10 days each calendar year	15% of negotiated fee rate and all costs for stays over 10 days	50% of customary and reasonable charges and any in excess and all costs for stays over 10 days
	▪ Outpatient basic mental health care services 15 visits each calendar year	15% of negotiated fee rate for 15 visits per year and all costs for over 15 visits	50% of customary and reasonable charges and any in excess and all costs over 15 visits
	▪ Unlimited inpatient days and outpatient visits for severe mental illnesses		
Alcohol and substance abuse treatment**	▪ Inpatient: As medically appropriate to remove toxic substances from the system	15% of negotiated fee rate	50% of customary and reasonable charges and any in excess
	▪ Outpatient: 20 visits per benefit year (the number of visits may be increased in a benefit year if outpatient services are determined medically necessary)	15% of negotiated fee rate for 20 visits per year and all costs for over 20 visits unless additional visits are determined medically necessary	50% of customary and reasonable charges and any in excess and all costs over 20 visits
Home health care	Home health services through a home health agency or visiting nurse association	15% of negotiated fee rate	50% of customary and reasonable charges and any in excess
Hospice	Hospice care for subscribers who are not expected to live for more than 12 months	15% of negotiated fee rate	50% of customary and reasonable charges and any in excess
Skilled nursing facilities	Skilled nursing care Covered when determined to be a medically appropriate more cost-effective alternative plan of treatment	15% of negotiated fee rate	50% of customary and reasonable charges and any in excess
Infusion therapy**	Therapeutic use of drugs, or other substances ordered by a physician and administered by a qualified provider	15% of negotiated fee rate	50% of customary and reasonable charges and any in excess for all infusion therapy related administrative, professional, and drugs
Physical/Occupational/ Speech Therapy	Services of physical therapists, occupational therapists, and speech therapists as medically appropriate on an outpatient basis	15% of negotiated fee rate	50% of customary and reasonable charges and any in excess

* Preventive care services are covered with no charge even if subscribers have not met the annual deductible.

** Exact terms and conditions of coverage will be provided to subscribers in the Certificate of Coverage booklet.

California PCIP Subscriber Premiums

Effective Through December 31, 2011

Age band	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
< 15	$ 145	$ 138	$ 140	$ 127	$ 142	$ 127
15 – 29	$ 199	$ 195	$ 201	$ 180	$ 200	$ 181
30 – 34	$ 286	$ 282	$ 292	$ 258	$ 288	$ 260
35 – 39	$ 319	$ 314	$ 325	$ 288	$ 321	$ 289
40 – 44	$ 337	$ 332	$ 344	$ 304	$ 339	$ 306
45 – 49	$ 369	$ 364	$ 377	$ 334	$ 371	$ 335
50 – 54	$ 494	$ 481	$ 499	$ 445	$ 495	$ 448
55 – 59	$ 627	$ 608	$ 624	$ 564	$ 625	$ 567
60 – 64	$ 796	$ 780	$ 802	$ 720	$ 799	$ 723
65 – 69	$ 891	$ 873	$ 899	$ 806	$ 895	$ 810
70 – 74	$ 939	$ 920	$ 947	$ 849	$ 943	$ 853
> 74	$ 995	$ 975	$1,003	$ 899	$ 999	$ 904

PCIP geographic regions: Counties in each region

Region 1 Northern: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Inyo, Kings, Lake, Lassen, Mendocino, Modoc, Mono, Monterey, Nevada, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo, Yuba

Region 2 Valley: Fresno, Imperial, Kern, Madera, Mariposa, Merced, Napa, Sacramento, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Sonoma, Stanislaus

Region 3 Bay Area: Alameda, Contra Costa, Marin, San Francisco, San Mateo, Santa Clara

Region 4 South Coast: Orange, Santa Barbara, Ventura

Region 5 Los Angeles: Los Angeles

Region 6 South: Riverside, San Bernardino, San Diego

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CALIFORNIA
PCIP
Pre-Existing Condition Insurance Plan

PCIP Supplemental Application Checklist

1. Please use the following checklist as you complete **both** the supplemental application **and** MRMIP application. The PCIP Supplemental Application is pages 7 – 8 of this document, **and** the MRMIP Application is pages 23 – 26 of the MRMIP Handbook.

- ☐ **Review** the PCIP and MRMIP comparison charts on page 2. The charts provide information about the different PCIP and MRMIP eligibility rules and benefits.
- ☐ **Complete** all questions on **both** applications, as they must be fully answered. If you do not provide all necessary information (including the required documentation, social security number, signature, and payment), the processing of your application will be delayed.
- ☐ **Sign and date** the completed PCIP Supplemental Application **and** the MRMIP Application.

2. **Attach** the following items below:

- ☐ **Supporting documentation** that indicates your eligibility for the PCIP and MRMIP.
  1. Proof of citizenship or immigration status.
  2. a) Copy of rejection letter for individual insurance coverage within the previous 12 months; **or**
     b) Copy of letter indicating individual coverage has been offered in excess of the MRMIP preferred provider organization (PPO) monthly premiums, in the geographic region where you reside. See MRMIP PPO monthly premiums pages 16 – 21 of the MRMIP Handbook.
- ☐ **A check** for one month's premium must be made payable to the **Managed Risk Medical Insurance Board** (or **MRMIB**) for the program you prefer on Question 13. (PCIP Monthly premiums are listed on page 5 of this document and MRMIP monthly premiums are on pages 16 – 21 of MRMIP Handbook). If you owe more money because you are not eligible for your preferred program, we will contact you. Under payment of premium will delay the processing of your application.

3. **Mail** the completed PCIP Supplemental Application **and** MRMIP Application **with** your check and all necessary supporting documents to:

California Pre-Existing Condition Insurance Plan
P.O. Box 537032
Sacramento, CA 95853-7032

Please be sure to send the correct premium for the program you prefer.

★ **Insurance agents or brokers:** You must complete **all** boxes at the bottom of page 23 of the MRMIP Application to request reimbursement.

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CALIFORNIA PCIP Pre-Existing Condition Insurance Plan

PCIP Supplemental Application

1. Applicant's last name		Applicant's first name	
2. Applicant's address			
City		State	Zip code
3. Applicant's birth date (mm/dd/yyyy)		**4.** Are you a California resident?	☐ Yes ☐ No

5. Are you a U.S. citizen or U.S. national? ☐ Yes ☐ No

A. If **yes**, you must send a copy of one of the following:

☐ Birth certificate ☐ Passport ☐ Certificate of U.S. citizenship or naturalization ☐ Other proof of citizenship

For U.S. Nationals, make sure you send papers that are not expired. Include copies of the front and back sides.

Skip to Question 7 after filling in 5B below.

B. Social Security Number (required):

6. Are you lawfully residing in the U.S.? *If **yes**, you must send proof of immigration status that shows the expiration date and is not expired. Include copies of the front and back sides.* ☐ Yes ☐ No

7. Have you received a denial letter from a health insurance company within the past 12 months because of a medical condition? *If **yes**, provide a copy of the **denial letter**.* ☐ Yes ☐ No

8. Have you received an offer of individual health insurance coverage within the past 12 months at higher rates than the MRMIP PPO Product? *If **yes**, provide a copy of the **offer letter**.* ☐ Yes ☐ No

9. Within the past 6 months, have you had any of the following types of health insurance coverage? ☐ Yes ☐ No

Please indicate by checking the boxes below.

- ☐ Individual or job-based health plan, including COBRA or Cal-COBRA
- ☐ Medicare Part A and/or Part B
- ☐ Medicaid
- ☐ Children's Health Insurance Program (or CHIP)
- ☐ A state high risk pool
- ☐ TRICARE (military health insurance)
- ☐ Health benefit plan provided to Peace Corps workers
- ☐ Health coverage provided by a public health plan established by a state, the U.S. government, such as coverage provided to veterans enrolled in VA health care, or a foreign country
- ☐ FEHBP (health insurance for Federal employees or retirees), including Temporary Continuation of Coverage (TCC)
- ☐ Services provided by the Indian Health Service or by a Tribe or Tribal organization for treating your medical condition

If you had health insurance within the past 6 months, please provide the reason your health insurance coverage ended:

- ☐ You or someone in your family lost or left their job
- ☐ Your insurance company stopped covering dependents
- ☐ You or someone in your family stopped working full-time and were no longer eligible for benefits
- ☐ You moved out of the insurance company's service area
- ☐ Your insurance premiums were too high
- ☐ Your COBRA coverage ended
- ☐ You voluntarily ended your insurance coverage
- ☐ You are no longer eligible for publicly-sponsored coverage
- ☐ Other. Explain the reason your coverage ended: _____

_____

_____

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10. Has your employer or an insurance company discouraged you from obtaining health insurance coverage that you were eligible for? *If **yes**, please provide more information below:*			☐ Yes ☐ No
Name of employer or health insurance company:			
Employer or health insurance company address:			
City	State	Zip code	
11. What language do you want us to speak to you in?			
12. What language should we write to you in?			
13. If you are eligible for both PCIP and MRMIP, indicate your preference for enrollment *(check **only one** box)*: *If you do not indicate your preference you will be enrolled into the PCIP.*			☐ PCIP ☐ MRMIP

Important Notices and Declarations

- I understand that it is my responsibility to inform PCIP of any health insurance coverage I get in the future or if I move out of California, so that I can be disenrolled.
- I understand that if I voluntarily disenroll from PCIP or if I am disenrolled involuntarily (for example, for failure to pay my premiums on time), I may not re-apply for enrollment until at least 6 months after my coverage ends.
- I understand and agree to the release of the application information to PCIP.
- I understand that my application and enrollment information may be shared with other government agencies for purposes of establishing eligibility for the PCIP.
- I declare that I have read and understand the information on this Supplemental Application and agree to these Notices and Declarations.

I certify that the information provided on this supplemental application is true, complete and correct to the best of my knowledge.

Applicant signs here ***(required):*** _____ Date _____

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